

Analysis of Medicaid Caseload Trends

Department of Health and Family Services
Office of Strategic Finance
Program Evaluation and Audit Section

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Executive Summary

Interest has been expressed in better understanding why the Wisconsin Medicaid (MA) caseload has continued to grow despite an improving economy. The state's unemployment rate declined from 5.6 percent in June 2003 to 4.5 percent in April 2005, yet total Medicaid enrollment grew by 10.2 percent during that time period. This report examines long and short-term caseload trends and factors affecting enrollment increases and declines.

Most caseload growth from 1987 through April 2005 was due to expansion of the eligibility pool as a result of creating major new programs. Since January 2001, when the health of the economy began to worsen, MA enrollment of low-income families (ie., AFDC MA caseload) has increased at a high rate, following some 7 years of decline and stabilization. Since January 2004, when the economy began to improve, AFDC MA enrollment has continued to increase, along with enrollment in Healthy Start and the Family Planning Waiver. However, even with this continued growth, April 2005 AFDC MA enrollment of 254,221 is well below yearly enrollment averages ranging from 280,000 to 295,000 in the late 1980s through 1993.

AFDC MA is the largest Medicaid program in which enrollment is closely correlated with changing economic conditions. Unemployment rate, number of manufacturing jobs, and a leading indicators variable developed by DWD are correlated with AFDC MA caseload, and can be used to predict AFDC MA enrollment levels. The strongest relationship was observed between AFDC MA caseload and leading indicators, followed by manufacturing jobs, then unemployment rate. Based on these relationships, predicted enrollment growth suggests that AFDC MA caseload should have increased more than it actually did from 2001 to 2004, but that downturns from these higher values should have started in 2004 or 2005.

Preliminary U.S. Department of Labor estimates available to state planners in 2004 and early 2005 overstated Wisconsin's gains in manufacturing jobs and employment. Projections of MA enrollment based on these estimates may have led to overly-optimistic expectations concerning the MA caseload. This report uses recent, adjusted estimates to analyze MA caseload trends.

Extensive outreach efforts for BadgerCare contributed to its rapid growth, and to a surge in Healthy Start enrollment, but the precise impact cannot be measured due to the way enrollment was structured. New enrollment outreach efforts continue to be implemented in 2004 and 2005. DHFS has spent at least \$17.5 million on outreach from 1998 through 2004.

Other factors may be contributing to continued Medicaid caseload growth. The most recent available data indicates that poverty in Wisconsin increased through 2003 and 2004, and included growth in female-headed households in poverty relative to 2002.

In addition, the number of persons using employer-sponsored insurance (ESI) in Wisconsin has declined, with the size and rate of decline among the highest in the nation from 2000 through 2003. Further, the number of Medicaid extensions granted to families with excess earnings has significantly increased, and there also has been growth in the number of young women of childbearing age.

Most recent AFDC MA enrollment growth has been outside Milwaukee County, with the highest rates in the Fox Valley counties, some north-central counties, and some border counties.

AFDC MA enrollment and total caseload growth slowed through the first five months of 2005 compared to the same time period during the previous four years. This may suggest that

enrollment is finally stabilizing. However, unemployment rates from January 2004 through May 2005 remain above the rates seen in June 1994, the last time AFDC MA caseload began to drop, and manufacturing jobs remain some 20,000 below the 1994 level last associated with declines.

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Background

Wisconsin's Medicaid (MA) caseload grew rapidly during the state's (and the nation's) recent economic downturn. Total Medicaid enrollment almost doubled from 395,336 in June 1999, when the state's unemployment rate was 3.0 percent, to 744,890 in June 2003, when unemployment rates reached 5.6 percent. Enrollment continued to increase even after the state's economic outlook began to improve. By April 2005, the unemployment rate had dropped to 4.5 percent, but total enrollment in Medicaid grew from June 2003 by 10.2 percent to 821,130.

This report examines the issue of the growth in the Medicaid caseload in Wisconsin, particularly in the face of improved economic conditions. The following questions are considered:

- to what extent are new programs and policy changes contributing to continued growth,
- what components of the total caseload are growing and why,
- what role has BadgerCare outreach and general Medicaid outreach efforts played in the growth of the Medicaid caseload,
- were the economic improvements observed in 2004 sufficient, based on previous trends, to slow or reverse growth, or is low-income family (AFDC) MA caseload simply returning to its historic size after the strong economic conditions of the 1990s ended,
- is there a time-lag between an improving economy and caseload changes, delaying the expected caseload slowdown or downturn,
- is caseload growth primarily occurring in Milwaukee or in other areas of the state,
- is growth resulting from increasing numbers of eligibles, or to better penetration due to the Department's outreach, and
- is caseload growth related to declines in employer-sponsored insurance in Wisconsin.

During the course of the analysis, the variable nature of estimates of manufacturing jobs and unemployment rates became apparent. Estimates are prepared by the US Department of Labor, Bureau of Labor Statistics (USDOL/BLS), and are used by the Wisconsin Department of Revenue (DOR) and the Wisconsin Department of Workforce Development (DWD) to make long and short term projections of the Wisconsin economy. Published USDOL/BLS estimates in late 2004 and early 2005 greatly overstated Wisconsin's recovery of manufacturing jobs in 2004, and to a lesser degree, underestimated the unemployment rate. More accurate estimates first became available in March and April of 2005, and were used for our analysis.

The current continuing growth of the AFDC MA and Healthy Start components of the Medicaid caseload are less surprising in light of these revised estimates. Therefore, the following question was added:

- how do current estimates of unemployment and manufacturing jobs compare with estimates from the fall of 2004 and early 2005, and what are the implications for Medicaid caseload trends?

Staff from the Bureau of Eligibility Management (BEM) in the Division of Health Care Financing (DHCF) assisted by providing a list of past program and policy changes, information on AFDC MA income, and information about outreach efforts and costs.

Research Method

The trends in Medicaid caseload and its components were charted and analyzed for several years along with new policies, programs, and historic factors.

DHFS outreach efforts to enroll eligible families in BadgerCare, AFDC MA and Healthy Start were reviewed and the costs of these efforts determined.

Caseload trends were analyzed along with three correlated economic predictors: unemployment rate, manufacturing jobs, and a composite variable of leading indicators, which is described later in this report. Regression analysis was used to predict expected AFDC MA caseload values based on these three economic predictors.

The four year period since the economic downturn at the start of 2001 and the 16 months since January 2004, when the economy began to improve, were analyzed in order to identify and describe recent growth trends within their longer historic context from 1987 through April 2005.

Wisconsin economic trends as projected by the Wisconsin Department of Revenue (DOR) and the Wisconsin Department of Workforce Development (DWD) were analyzed, and analysts at DOR and DWD were interviewed.

Trends in other demographic and insurance-related factors (e.g., poverty rates, single parent families in poverty, employer sponsored insurance) were reviewed, and patterns compared with caseload growth.

Questions and Analysis

We present a series of questions, information and analysis pertaining to the overall issue of documenting Medicaid enrollment trends and explaining the reasons for increases and decreases over time.

Enrollment Growth Trends

Question #1: To what extent is past and current caseload growth due to new policies, programs, or historic factors?

We reviewed enrollment trends for three time periods: a long view that covers an 18 year time frame, and two short views, one beginning around January 2001, when the recent economic downturn began, and the second starting January 2004, after the economy began to improve.

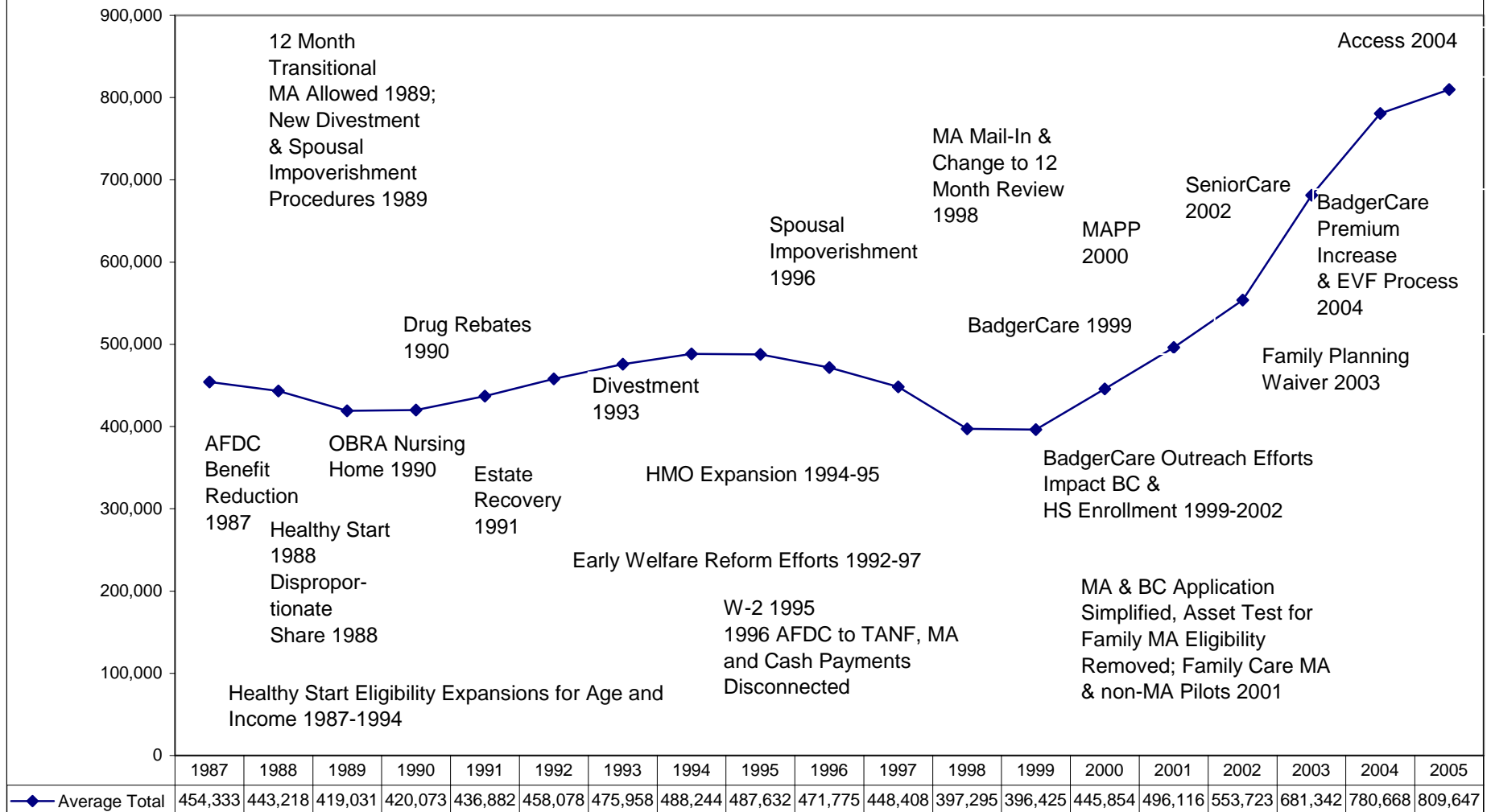
Long-term overview. Total Medicaid enrollment in SFY 1987 averaged 454,333, which compares with an average enrollment of 809,647 through April of SFY 2005. Most of this growth was due to expansion of the eligibility pool due to implementation of major new programs. Graph 1 charts average total caseload growth during this 18 year period, with a timeline of the major program and policy changes. Graph 2 shows the impact of new programs on total caseload since 1989, as well as trends in the AFDC MA component.

For the first 10 years of this time period, from 1987 through 1997, average annual enrollment in Medicaid never went below 400,000 or above 500,000. Enrollment dropped below 400,000 for the first time in 1998, when average annual enrollment was 397,295. Enrollment stayed at historic low levels in 1999, at 396,425. The major reason for achieving these low enrollment levels was declining participation in the AFDC MA benefits program. Enrollment in AFDC MA peaked at about 294,000 in 1992 before falling to 130,412 in June 2000.

The decline was largely due to two factors. The first was a strong economy featuring very low unemployment in Wisconsin, and record numbers of manufacturing jobs, averaging over 590,000 from 1998 through 2000. The second factor was welfare reform, which began in the early 1990s and led to the establishment of Wisconsin Works (W-2) in 1995. In 1996, the United States Congress replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF) by approving the Personal Responsibility and Work Opportunity Act of 1996. This legislation changed welfare from a cash-aid entitlement program to a temporary cash-aid, work-assistance program. It also ended the automatic eligibility link between AFDC and Medicaid. AFDC MA enrollment in Wisconsin dropped by about 40,000 in 1996, but the period following W-2 TANF implementation (October 1996) saw the sharpest decline; the AFDC MA caseload dropped by over 60,000 persons in 1997.

Enrollment During the Economic Downturn. Long term trends are informative and offer important context, but policy makers have a more immediate interest in understanding the sources of growth in Medicaid enrollment since the recent economic downturn through the present. For our analysis, we considered January 1, 2001 as the date that the economic downturn began. At this point, unemployment rates had increased to 3.7 percent, and continued to rise above 4 percent thereafter.

**Graph 1: Total Medicaid Enrollment and Major Program/Policy Changes,
SFY 1987 through April 2005**



The table below shows the change in enrollment from January 1, 2001 to May 1, 2005 for Medicaid overall and for its major components. During this time period, enrollment in Medicaid increased 67 percent, from 491,977 to 821,383. Enrollment in AFDC MA increased by 124,692 or 96 percent, the highest rate of growth in Table 1. This is not surprising since eligibility for AFDC MA is determined by family income, and the number of lower income families in need of health insurance increases when jobs likely to offer health insurance are lost.

**Table 1: Growth in Enrollment in Medicaid
Programs From January 1, 2001 to
May 1, 2005**

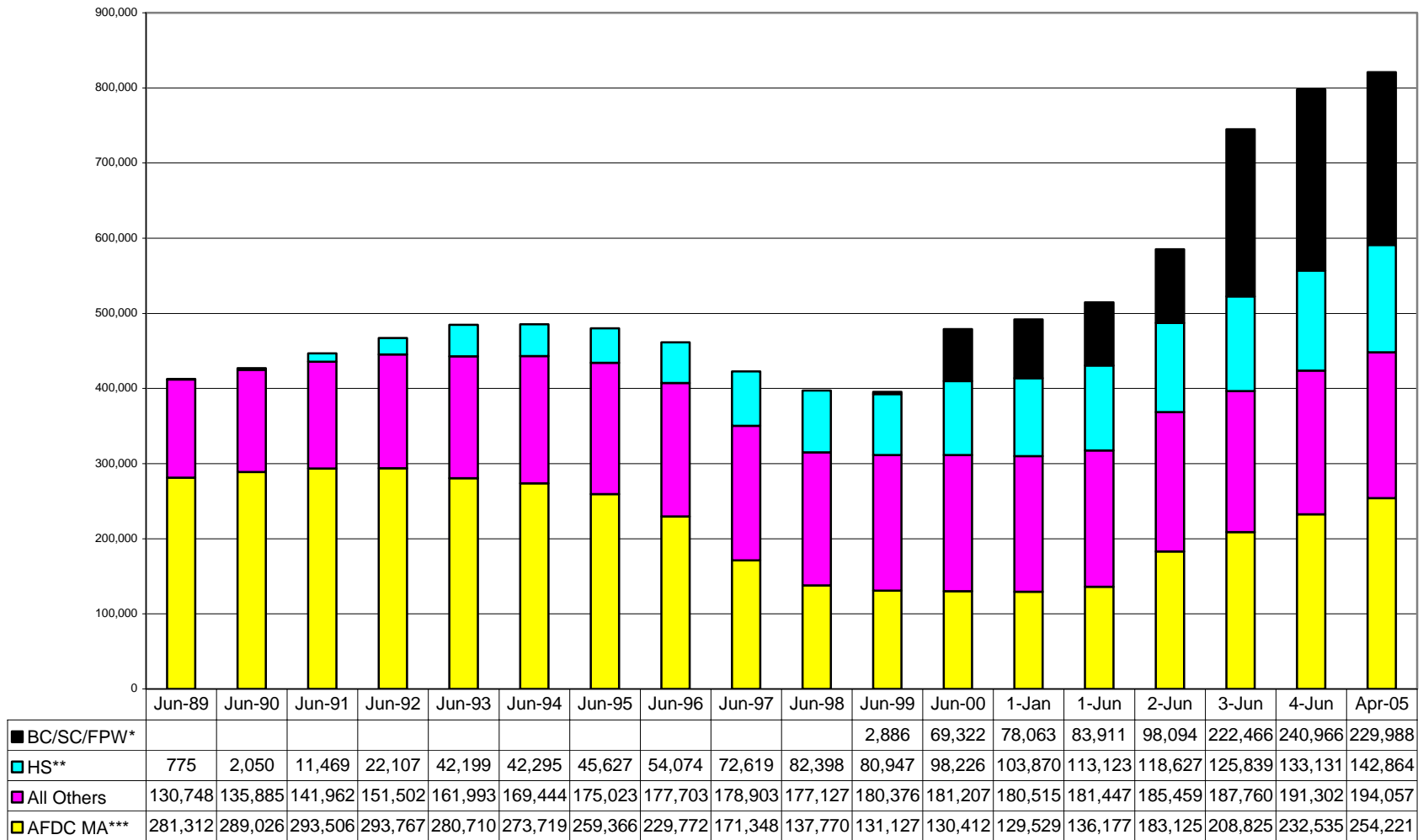
<u>Program</u>	<u>January 1, 2001</u>	<u>May 1, 2005</u>	<u>Growth</u>	<u>Percent Growth</u>
AFDC MA	129,529	254,221	124,692	96%
BadgerCare	78,063	89,494	11,431	15%
Senior Care	0	87,000	87,000	100%
Healthy Start	103,870	142,640	38,770	37%
Family Planning Waiver	0	52,971	52,971	100%
All Other	180,515	195,057	14,542	8%
Total	491,977	821,383	329,406	67%

However, as the table shows, a significant portion of the growth in this time period is due to the addition of new programs or rapid growth in programs that had only recently been created. BadgerCare, SeniorCare and the Family Planning Waiver combined to add 151,402 enrollees during this period, while another 38,770 became eligible for Healthy Start.

It is assumed that most growth in these programs was simply due to broadening the eligibility pool by adding additional population groups within a wider income range, and the outreach attempts designed to maximize enrollment. However, income is a factor in eligibility for all of these programs, and the increasing number of lower income families after 2001 undoubtedly contributed to growth in the number of people eligible to some extent.

Medicaid caseload grew across the nation from 1997 through 2003, due to the State Children's Health Insurance Program (SCHIP) initiatives. Wisconsin's Medicaid percentage increase from SFY 1997 through SFY 2003 was higher than neighboring states and the nation as a whole. A slowdown in the national rate of growth in SFY 2003 was attributed to actions taken by at least 25 states to limit enrollment. See Appendix I for comparative data and a description of these results.

Graph 2: Caseload Growth and Composition, June 30, 1989 through April 2005



*This includes BadgerCare, SeniorCare and Family Planning Waiver.

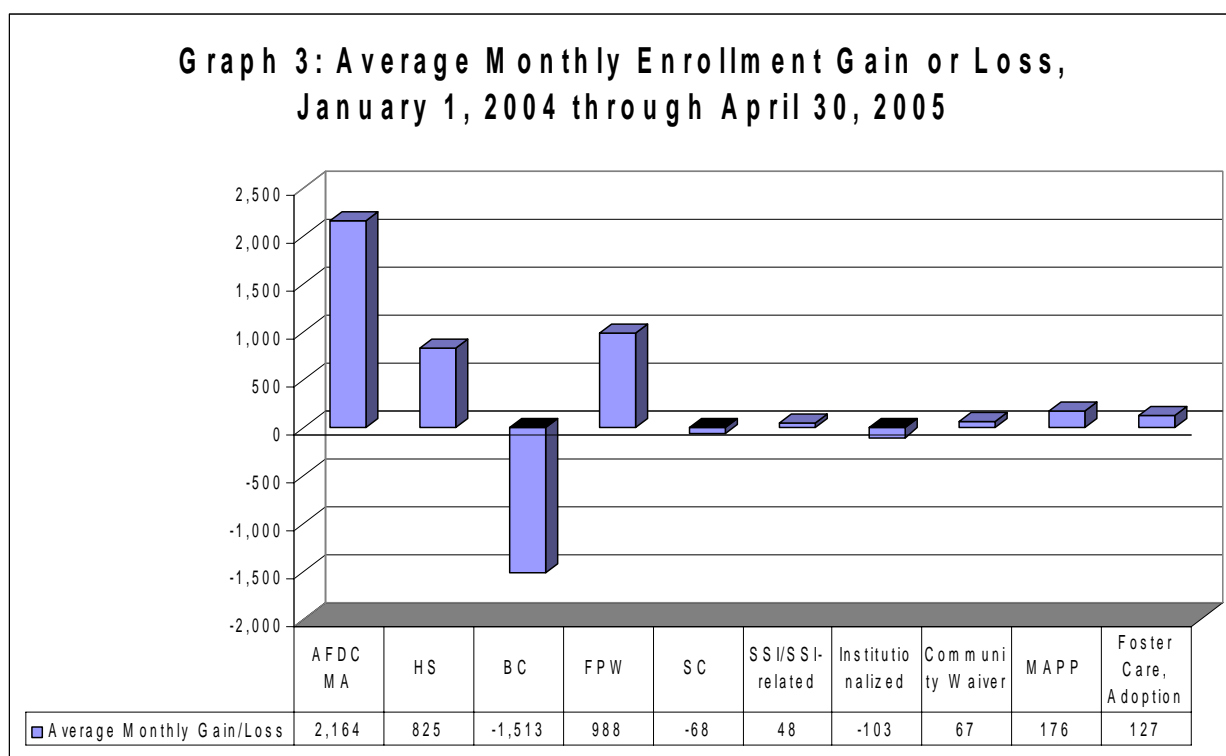
**This includes Healthy Start.

***This includes Low Income Family Medicaid.

Question #2: What components of the caseload continued to grow after the economy began to improve in 2004?

Graph 3 below shows the average monthly MA caseload growth, by various component programs, since the economic upturn began in January 2004. An average of 2,164 persons were added to AFDC MA per month, and another 825 per month were added to Healthy Start. A partial benefits program, the Family Planning Waiver added an average of 988 persons per month. Much smaller monthly growth in MA Purchase Plan (MAPP) and Foster Care/Subsidized Adoptions also continues.

As shown below, BadgerCare enrollment decreased by an average of 1,513 persons per month. This is likely due to implementation of a new policy measure requiring employment and insurance verification.



It is worth noting that while AFDC MA enrollment has continued to grow, April 2005 enrollment of 254,221 is still well below yearly averages in the 280,000 to 295,000 range of the late 1980s through 1993. (See Graph 2.) The 290,000 enrollees in 1990 represented about 6.8 percent of Wisconsin's population age 0 to 65 at that time. The 254,221 enrolled in April 2005 represent about 5.8 percent of persons age 0 to 65 years; 6.8 percent of today's group would include 316,956 persons.

Question #3: How do current estimates of unemployment and manufacturing jobs compare with estimates from the fall of 2004 and early 2005, and what are the implications for predicting Medicaid caseload?

As we learned during the analysis, unemployment and manufacturing jobs are both good predictors of the AFDC MA component of the Medicaid caseload. However, the initial estimates of these variables are based on various surveys, and are later revised as administrative records are transmitted to the United States Department of Labor/Bureau of Labor Statistics (USDL/BLS) from the states. As a result, USDL/BLS estimates often change months after they are first published. Further, the monthly unemployment rates for the last 30 years were re-estimated using a new formula in March 2005, changing the entire historical data base.

Estimates of Wisconsin manufacturing jobs and unemployment during 2004 were revised downward in April 2005 from estimates posted last winter and as recently as March 2005.

The two most recent Wisconsin Department of Revenue (DOR) Wisconsin Economic Outlook Reports were published March 2, 2005 and May 31, 2005.¹ The earlier relied on data available before February 7, 2005, while the more recent report incorporated data available since then. Within each report are short-term (by quarter, one year into the future) and long-term (by year, through 2009) projections for many economic indices. The unemployment and manufacturing jobs projections are based largely on USDL/BLS estimates.

The DOR short-term reports estimate and project manufacturing jobs and unemployment by quarters. The March 2005 DOR Report projected a recovery to over 525,000 Wisconsin manufacturing jobs by the end of 2005, based on previous *estimated* growth in 2004 to 518,600 jobs by quarter four.

However, the May 2005 DOR analysis, based on revised USDL/BLS estimates, shows that the 2004 recovery only reached about 503,500 manufacturing jobs in quarter four, with growth through the end of 2005 now projected to be 504,300, rather than the 525,000. Unemployment estimates and projections were also revised slightly upward in the May report, compared to March.

DOR's long-term projections, through 2009, show a similar pattern. The March 2005 report projected an increase to 522,400 manufacturing jobs through 2005, and a recovery to 541,800 in 2009. The May report, on the other hand, projects 503,600 manufacturing jobs in 2005 (up from a yearly average of 502,000 in 2004), with further increases to 518,500 in 2009.

The March 2005 DOR long-range estimates for unemployment were 4.9 percent in 2004, 4.6 percent in 2005, and 4.4 percent in 2007. The May 2005 report revises these estimates to 5.0 percent in 2004, and 4.7 percent in 2005 and continuing through 2007.

The Wisconsin Department of Workforce development (DWD) also bases its short-term projections on USDL/BLS estimates, and predicted an increase of about 8,000 manufacturing jobs between 2003 and 2005.² However, the revised estimates now available from USDL/BLS show a decrease of about 2,000 such jobs during the 2004 recovery, compared to 2003 levels.

¹ Wisconsin Economic Outlook, Wisconsin Department of Revenue, Quarterly Reports issued March 2, 2005 and May 31, 2005.

² Wisconsin Projections, 2003-2005 Highlights, Wisconsin Department of Workforce Development, undated, page 6.

This discussion is intended to illustrate that the very best economic estimates of these two variables are volatile in the short term, and that the resulting projections by the best economists and statisticians are subject to change. (Similarly, estimates cited in this report, based on 2005 survey data, are also likely to change as more precise data become available.)

In hindsight, estimates of manufacturing job growth and unemployment rates in 2004 were too positive, and assumptions made about their effect on the Medicaid caseload may have been overly optimistic. As a consequence, continuing growth in the AFDC MA caseload should be less surprising than it was a few months ago.

Caseload Growth Trends and Economic Factors

Question #4: Which Medicaid Caseload populations are associated with economic measures?

We compared each of the major components of Medicaid caseload with three standard indicators of economic activity: unemployment rate, number of manufacturing jobs, and a composite index of leading indicators of economic activity prepared by DWD, which is made up of five other indicators.³ The goal of this analysis is to determine which MA program components' enrollments rise or fall with changes in economic conditions.

We observed no correlation of Healthy Start enrollment with these economic variables over the 15-year time period we studied. Healthy Start enrollment has steadily risen regardless of economic trends. BadgerCare, SeniorCare and the Family Planning Waiver all have statistically significant correlations with unemployment, manufacturing jobs and leading indicators, but the programs are too new to allow for meaningful variation with the economy. That is, all of these programs started during a four year period when unemployment was only increasing, and the other two measures were declining. The recent drop in BadgerCare enrollment, beginning January-May 2004, is associated with program changes, specifically a premium increase and the implementation of a new employer verification form (EVF) process.

However, over the last 15 years, AFDC MA enrollment is significantly correlated with the three economic indicators used in our analysis. The first of these is unemployment ($r = .52$), as shown in Graph 4.⁴ This means that higher enrollment levels have occurred over the last 15 years when the unemployment rate is also high.

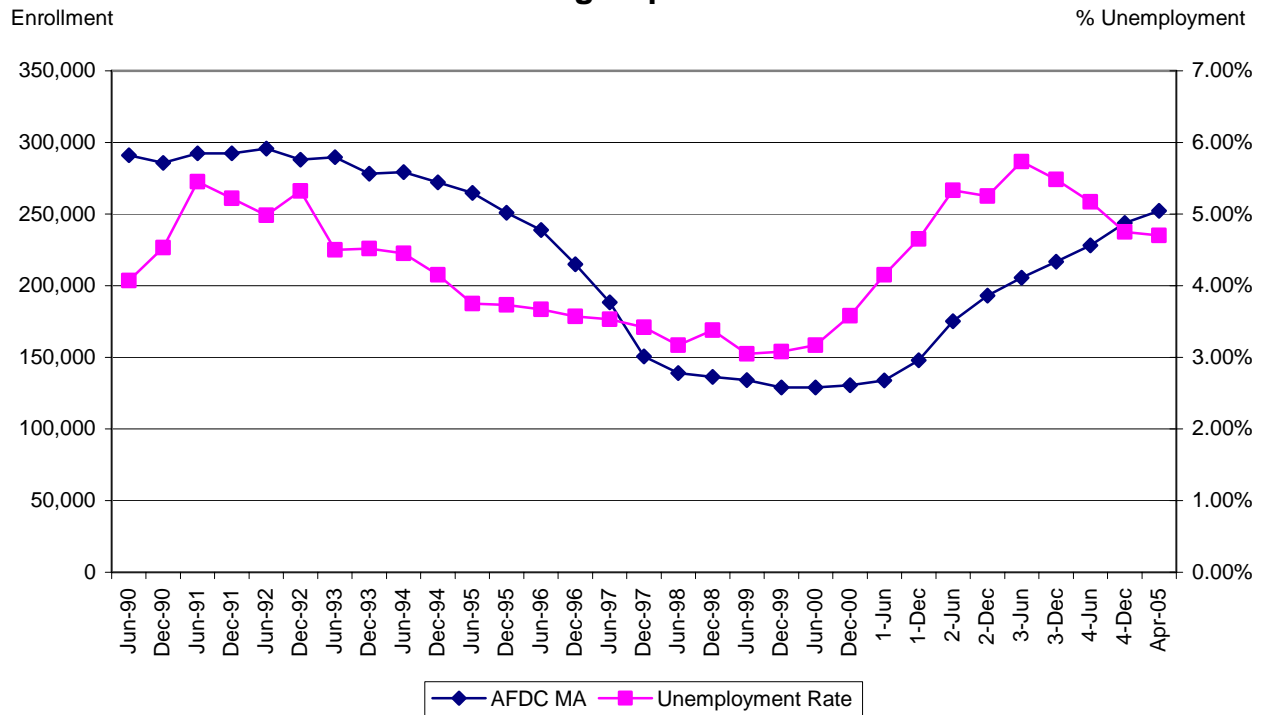
The inverse correlation between manufacturing jobs and AFDC MA is stronger ($r = -.70$) than the unemployment-AFDC MA relationship, as shown in Graph 5. That is, enrollment has historically decreased when the number of manufacturing jobs increases.

Finally, the inverse correlation between DWD's leading indicators index and AFDC MA is the strongest yet ($r = -.80$). (See Graph 6.) Index readings above 100 points indicate economic prospects that are better than the outlook during the base year of 1994.

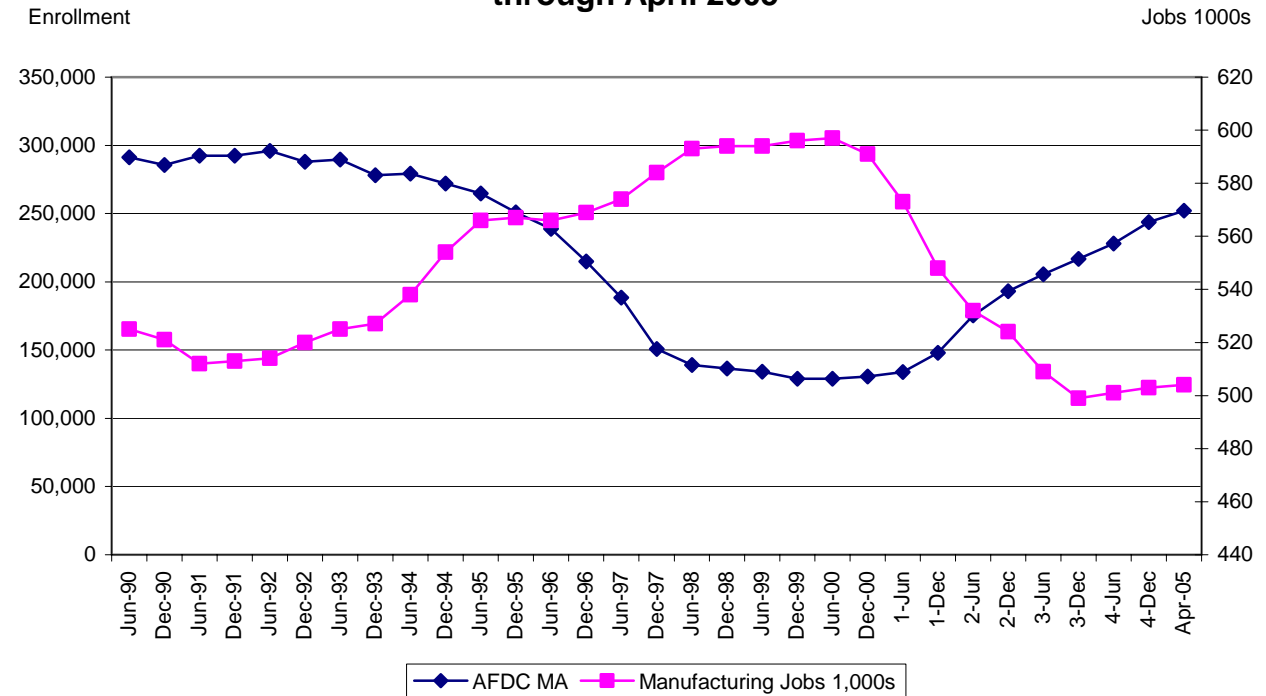
³ Combining five indicators into one index makes the blended indicator more reliable than any single indicator. The five indicators are average work week, average overtime hours, average weekly initial claims for unemployment compensation, total job openings received, and new business incorporations. More information can be found on the DWD website at http://dwd.wisconsin.gov/oea/wi_econ_indicators.htm

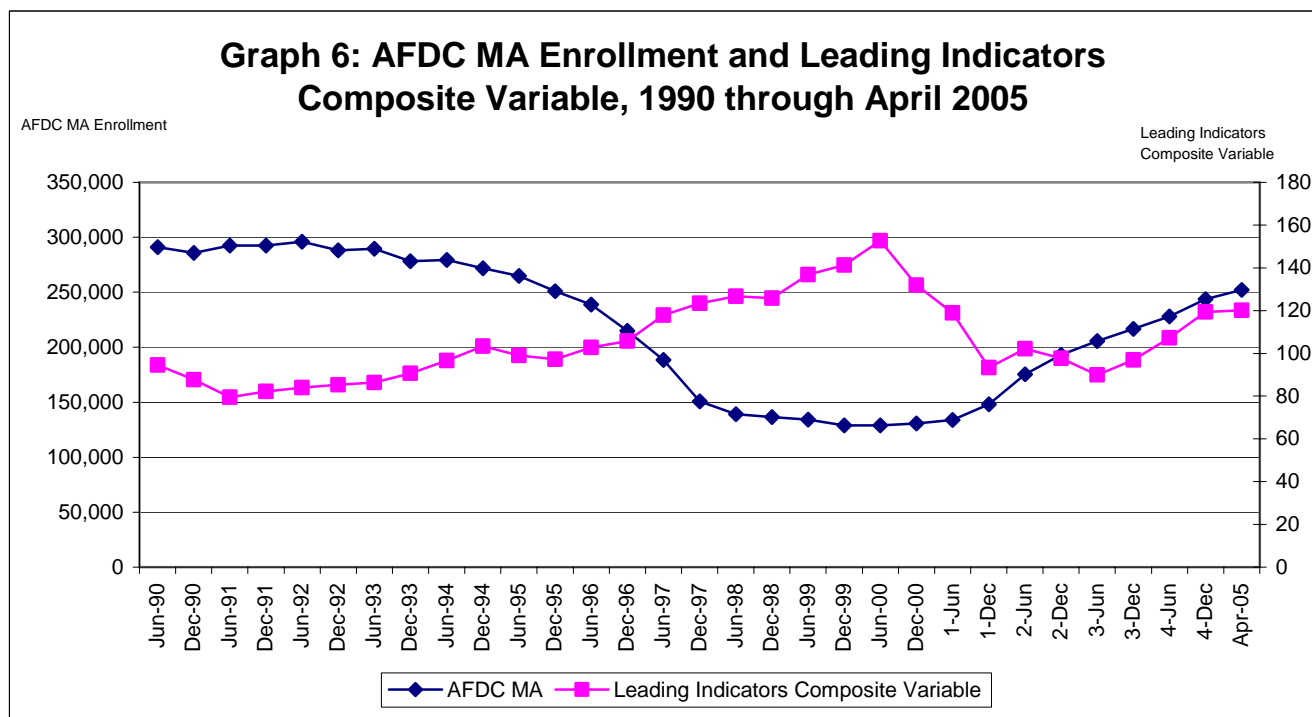
⁴ r refers to the correlation coefficient, a statistic that measures the positive or negative (inverse) association between two numerical variables. It ranges from +1.0 to -1.0. The strength of the relationship increases as r approaches +1.0 or -1.0, and weakens as it approaches zero. An r value of zero indicates that there is no relationship between the two variables.

Graph 4: AFDC MA Enrollment and Unemployment Rate, 1990 through April 2005



Graph 5: AFDC MA Enrollment and Manufacturing Jobs, 1990 through April 2005





Question #5: What does the statistical relationship between AFDC MA enrollment and the selected economic measures predict with regard to AFDC MA enrollment growth?

The correlations observed between the AFDC MA caseload data and measures of economic activity increased when economic activity was lagged 12 months behind caseload. This seems reasonable, as the effect of declining employment on AFDC MA enrollment may not be evident right away, as families use up other resources available to them before seeking public assistance in paying for health care. To observe this effect, caseload was regressed on each of the three lagged economic variables, and predicted values generated.

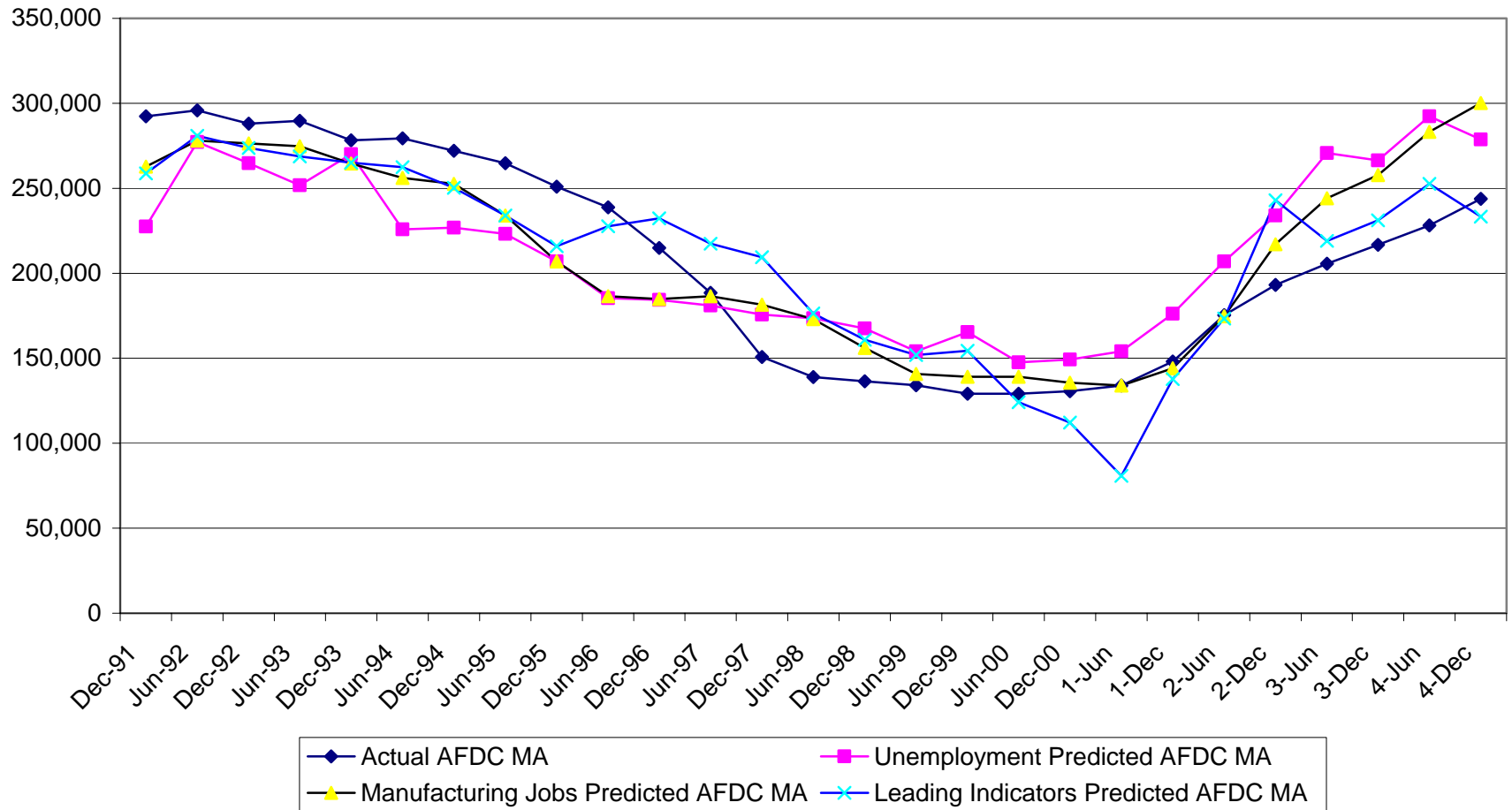
For unemployment, lagging by 12 months increased the correlation from $r = .52$ to $r = .73$. The regression shows that 53 percent (r squared) of the statistical variation in AFDC MA enrollment from month to month is explained by changes in the unemployment rate that occurred 12 months before.

Lagging manufacturing jobs by 12 months increased its correlation with AFDC MA caseload from $r = -.70$ to $-.88$. Therefore, 77 percent of the statistical variation in AFDC MA enrollment is associated with changes in the number of manufacturing jobs that occurred 12 months before.

For the DWD's composite index, lagging by 12 months increased the correlation from $-.80$ to $-.88$. That is, fully 79 percent of the variation in AFDC MA enrollment from month to month is explained by changes in the DWD's composite index that occurred 12 months before.

Graph 7 combines the results of these three analyses, charting the actual AFDC MA caseload against the hypothetical enrollment predicted by each of the three lagged economic variables.

**Graph 7: Actual and Predicted AFDC MA Enrollment, 12 Month Lagged
Unemployment, Manufacturing Jobs and Leading Indicators**



For the most part, the predicted caseload growth, based on the economic variables, suggest that AFDC MA caseloads should have increased more than they actually did from 2001-2004, but that downturns from these higher enrollment levels should have occurred in 2004.

The statistical relationship between AFDC MA caseload and a 12 month lagged unemployment rate, in Graph 7, suggests a downturn in caseload should have occurred from June 2004 through December. The model also predicts that AFDC MA enrollment should have increased much more than it actually did from 2001 through 2004 when unemployment was rising. Therefore, the predicted statistical values for the downturn remain above actual enrollment.

The statistical relationship between AFDC MA caseload and 12 month lagged manufacturing jobs (Graph 7) also predicts that AFDC MA enrollment should have increased much more than it actually did from 2002 through 2004. The predicted data suggest that AFDC MA caseload should still be increasing in light of low numbers of manufacturing jobs.

The statistical relationship between AFDC MA caseload and 12 month lagged composite leading indicators variable, in Graph 7, suggests that AFDC MA caseload should have decreased slightly below the actual AFDC MA enrollment in the latter half of 2004, in light of rising leading indicators the year before. The predicted enrollment was only slightly higher than the actual enrollment in this model.

Other Contributing Factors

Question #6: What role have outreach efforts designed to increase penetration into eligible non-enrollees played in the growth of the Medicaid caseload?

During the transition from AFDC to TANF in 1996-1997, most families leaving AFDC for W-2 were eligible for transitional health insurance. Despite this, the number of uninsured families and children grew rapidly in Wisconsin and the nation. The main problem was thought to be lack of knowledge; families were either unaware of, or did not know they were eligible for, public health insurance after welfare and Medicaid were delinked.

The federal Balanced Budget Act of 1997 included funding for the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act. The goal of SCHIP is to provide, expand and maintain health insurance coverage for low-income children who would otherwise be uninsured.

In Wisconsin, the Governor, the Legislature, and the DHFS were concerned by the growing number of uninsured in the wake of W-2. As a result, state officials made outreach a priority when they designed BadgerCare, Wisconsin's SCHIP program.

BadgerCare outreach and enrollment policies and procedures are well documented in Wisconsin's annual SCHIP reports to CMS⁵, the Sirica study⁶ and elsewhere. The efforts were extensive, and include the selection of the non-pejorative name "BadgerCare," starting as a Medicaid expansion program rather than as a stand-alone SCHIP program, sharing application stations and forms with AFDC MA and Healthy Start, television and radio campaigns, outreach in the schools, developing additional enrollment stations, including adult family members in the program, simplifying the application process, and adding a mail-in option in 2001.

⁵ Annual Reports of State Children's Health Insurance Plans Under Title XXI of the Social Security Act, Federal Fiscal Year 2000-3, Wisconsin Division of Health Care Financing.

⁶ The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP), by Coimbra Sirica, The Milbank Fund, January 2001.

Because all applicants complete the same eligibility process, and are checked for AFDC Medicaid and Healthy Start before being screened for BadgerCare, it is impossible to count the exact number of persons who came to apply for BadgerCare, but were screened into AFDC Medicaid and Healthy Start instead. Therefore, it has been impossible to directly measure the impact of outreach efforts on enrollment for any of the three programs, except in the most general sense. Despite this, changes in enrollment rates and patterns immediately after BadgerCare start-up could indicate a general impact if contrasted with the pre-start-up time period. The DHFS evaluation of BadgerCare⁷ examined enrollment data for AFDC MA and Healthy Start for the year before BadgerCare, and for two years after it started, from April 1999 through March 2001.

That analysis showed that a sharp increase in the number of Healthy Start children and pregnant mothers occurred in the months following April 1999, just as BadgerCare outreach and enrollment started. The high rate of growth in Healthy Start continued through September 2001, before slowing somewhat. BadgerCare also grew very quickly, and enrollment quickly surpassed projected expectations. However, AFDC MA enrollment did not show the rapid upward growth seen in Healthy Start; in fact, the rate of enrollment dropped somewhat during the year following BadgerCare start-up, and remained rather static for another year before beginning to increase around April 2001, two years after BadgerCare began.

It is possible that recent growth in AFDC MA enrollment has been facilitated by the de-stigmatizing approach taken with BadgerCare, and by the structural changes that linked the enrollment process of the three major family Medicaid programs. However, the 2001 downturn in the economy, decreased manufacturing jobs, and increased unemployment are probably the most important causes underlying the growth of AFDC MA caseload over the last four years.

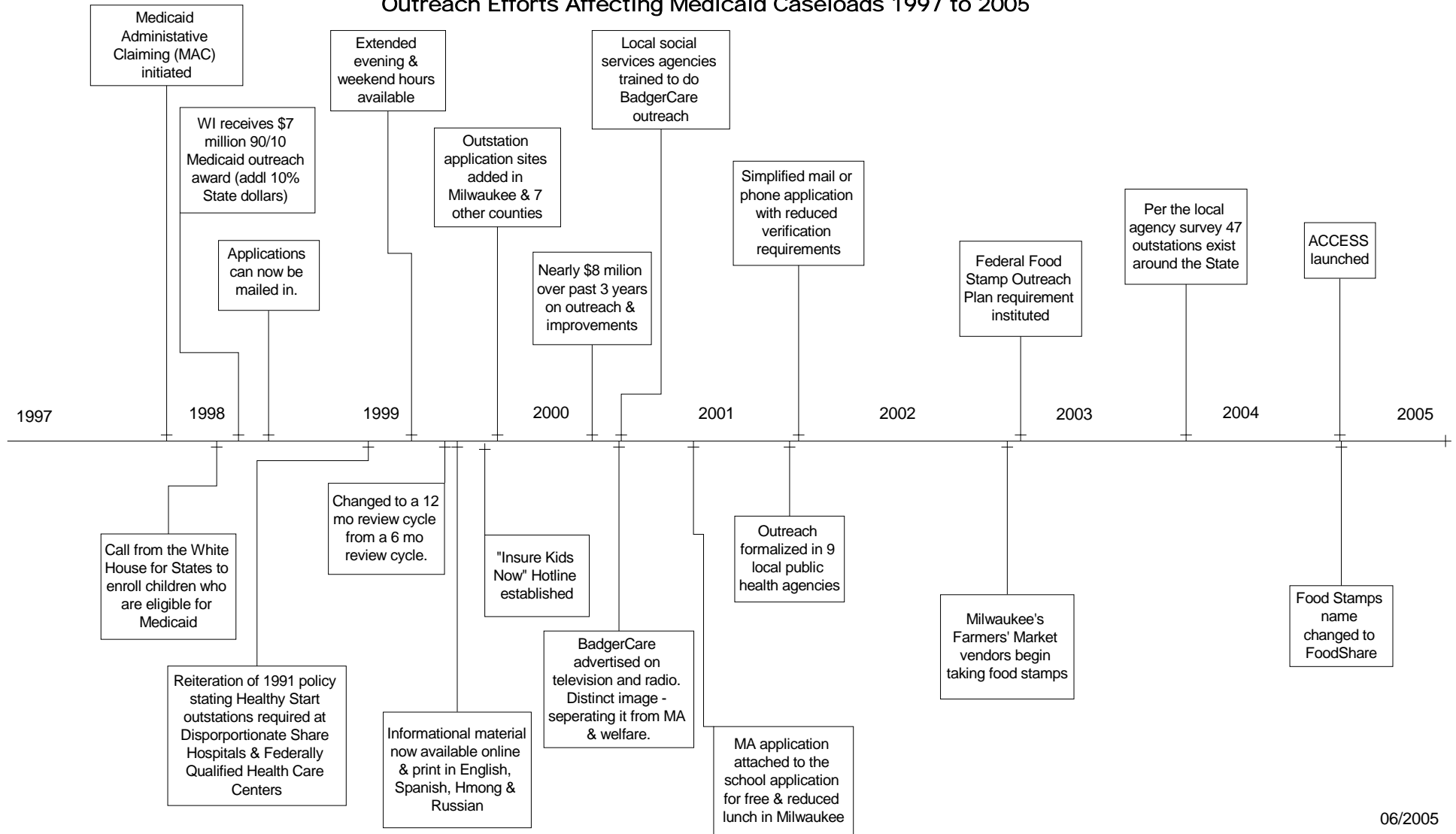
The DHFS has expended considerable effort in developing extensive outreach efforts that have been funded by grants. Outreach activities are outlined on the attached Chart 1: Outreach Efforts Effecting Medicaid Caseloads 1997 to 2005. These include:

- DHFS received a \$7 million federal grant in 1998, which required 10 percent state matching funds, designated for outreach efforts. It was designed to counteract the rapidly declining participation rates in Medicaid in the wake of federal action replacing Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF).
- The federal USDA awarded a \$1.7 million grant in 2003 to develop and implement Internet-based tools that will more directly connect low-income consumers with public benefits programs. The ACCESS website was launched in August 2004.
- DHFS received a \$500,000 grant from the Wellpoint Foundation, which was matched with federal funding for a total funding amount of \$1 million dollars. The grant is targeted toward outreach in Milwaukee County and the school districts of Janesville and Beloit. The contract to oversee the grant was awarded to Community Advocates with an estimated start date in the school district of February 2005 and March 15, 2005 in Milwaukee County.

⁷ BadgerCare Evaluation, Office of Strategic Finance, July 2004.

Chart 1

Outreach Efforts Affecting Medicaid Caseloads 1997 to 2005



06/2005

- From 1998 to 2004, the Department reported spending \$17.5 million on outreach efforts to the federal Centers for Medicare and Medicaid Services (CMS). The federal funding accounted for 90 percent of the expended amount. The \$17.5 million represents only those outreach related expenditures that were separately labeled and easily identified in CMS reports, and does not include spending on on-going outreach related activities built into the state's and counties' budgets.

Question #7: What other factors may contribute to the continuing growth in the AFDC MA caseload?

Medicaid Extensions: The number of Medicaid extensions, or transitional Medicaid, applying to AFDC MA enrollees for excess income and loss of income disregard has increased sharply over the last three years from 27,840 in January 2002 to 50,510 persons in April 2005. The majority of these (46,763) are for excess earnings. The excess earning extension allows the family to remain on Medicaid for 12 months after the case exceeds income eligibility limits. Many of these families fluctuate above and below the income limits as time passes.

The increase in these extensions could indicate rising income among enrollees, or it could represent greater instability in employment opportunities or both. Whatever the cause, increasing numbers of extensions will keep more people enrolled for longer periods, delaying enrollment drops predicted based on an improving economy.

Increasing Poverty: Since data on poverty is collected less frequently than unemployment data, the latest available information on poverty rates is for 2004. Data from the U.S. Census Bureau indicate that the number of persons 0 to 64 years of age living in poverty (less than 100 percent Federal Poverty Line, or FPL) increased in Wisconsin from 2002 through 2004, but that the number between 101 percent and 185 percent FPL decreased. A summary is presented in Table 2.

The census data discussed below have a high margin of error. However, taken over the three year period, the large changes appear to represent a reliable trend. Moreover, growth in poverty in Wisconsin has been independently observed by the DHFS Bureau of Health Information and Policy's (BHIP) Family Health Survey, 2002 through 2003.

According to the Census Bureau:

- 474,000 people between the ages of 0 to 64 (or 10 percent of this age group) lived in households with income at or below 100 percent of the FPL in 2003, which was an increase of 64,000 (or 15.6 percent) from 2002; this number increased to an estimated 619,000 in 2004, an increase of 145,000 people (or 30.6 percent) from 2003.
- 1,103,000 people between the ages of 0 to 64 (or 23.2 percent of this age group) lived in households with income at or below 185 percent of the FPL, which was an increase of 87,000 (or 8.6 percent) from 2002; the number increased to 1,155,000 in 2004, an increase of 52,000 from 2003, or 4.7 percent. However, this increase was due to the growth in the number of people under 100 percent FPL; the number of people between 101 and 185 percent FPL dropped by 93,000.

The Census Bureau estimates also showed an increase in the number of people in female-headed families under 100 percent FPL from 2002 through 2004:

- 234,000 people living in female-headed families (or 43.2 percent of this group) were estimated to be in households with income at or below 100 percent of the FPL in 2003, which was an increase of 76,000 (or 48 percent) from 2002; the number declined in 2003, but was still some 43,000 higher than in 2002.
- 354,000 people living in female-headed families (or 65.4 percent of this group) lived in households with income at or below 185 percent of the FPL in 2003, which was an increase of 64,000 (or 22 percent) from 2002. This number decreased by some 20,000 from 2003 to 2004.

Although the FPL is markedly higher than Wisconsin's AFDC MA eligibility level (roughly 40 percent of FPL in many cases), the increasing number of people under 100 percent FPL does generally coincide with the expansion of eligibles in AFDC MA and Healthy Start in recent years.

Table 2: Poverty in Wisconsin 2002-2004

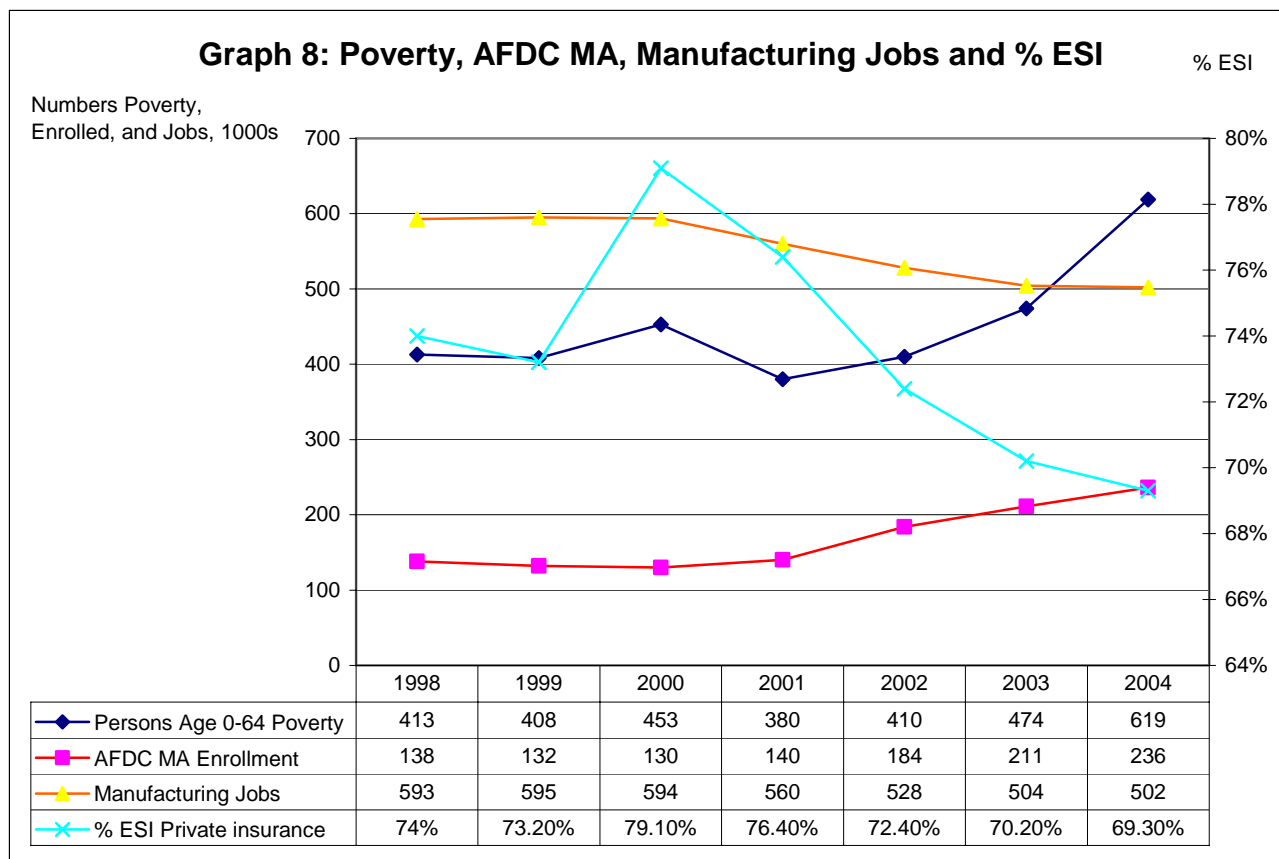
	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>Change 2002-2004</u>
Age 0-64, under 100 FPL	410,000	474,000	619,000	+209,000
Age 0-64, 101-185 FPL	606,000	629,000	536,000	-70,000
Age 0-64, under 185 FPL	1,016,000	1,103,000	1,155,000	+139,000
Female headed households, under 100 FPL	158,000	234,000	201,000	+43,000
Female headed households, 101-185 FPL	132,000	120,000	112,000	-20,000
Female headed households, under 185 FPL	290,000	354,000	313,000	+23,000

Demographic Trend: Census estimates indicate that the number of women between 20 and 30 years of age has increased in Wisconsin by nearly 30,000 in the last four years. Growth in this group is most likely to add to the pool of young mothers and children eligible for benefits in AFDC MA and Healthy Start.

Employer Sponsored Insurance (ESI): ESI is regarded by many as the backbone of private sector health insurance. The number of employers *offering* health insurance plans, the number

of employees *eligible* for offered plans, and the number of eligible employees *using* offered plans are all likely to be inversely associated with Medicaid enrollment.

Census Bureau data indicate that the percentage of all persons under 65 years of age with employment based health insurance in Wisconsin declined from 2000 through 2004, around the same time that manufacturing jobs decreased, the number of Wisconsin working age adults and children in poverty rose, and AFDC MA caseload increased. (See Graph 8) These events could be related, with falling manufacturing jobs logically affecting the others.



In addition, DHFS information from sequential “Wisconsin Health Insurance Coverage” reports also show a drop in ESI coverage for working-age people from 2001 through 2003. The reports estimate that ESI coverage fell from 81 percent in 2001 to 77 percent in 2003 for people age 45-66. For people age 18-44, the decline was from 76 percent in 2001 to 73 percent in 2003.

The Urban Institute and Kaiser Commission have analyzed Census Bureau data, and compared the number of people using different types of coverage. The results for Wisconsin showed significant declines in the number (-333,554) and percent (-7.7) of non-elderly persons covered by ESI from 2000 through 2003. These losses placed Wisconsin among the hardest hit in the nation; only four states lost a greater number of workers using ESI, and only two states had a higher percentage loss.

Question # 8: Where is AFDC MA growth occurring in Wisconsin and are some areas showing more rapid growth?

Most recent AFDC MA enrollment growth has been outside Milwaukee County. Milwaukee County had 74,302 AFDC MA enrollees, or 57 percent of the statewide enrollment in January 2001, compared to 56,237 (or 43 percent) in all other Wisconsin counties. By January 2005, this relationship was reversed. There were 154,612 (62 percent) AFDC MA eligibles in other counties compared to 95,325 (38 percent) in Milwaukee County. Milwaukee's growth rate was 28 percent during this period, while the average AFDC MA caseload of the balance of the state grew 175 percent.

A more detailed analysis of all Wisconsin counties by number and percent of increase in AFDC MA enrollment over the same period is presented in Map 1. It shows that most recent growth in AFDC MA occurred in the Fox River Valley counties, north-central counties including Marathon, Taylor, Clark and Chippewa, and some counties bordering Minnesota, Iowa, and Illinois.

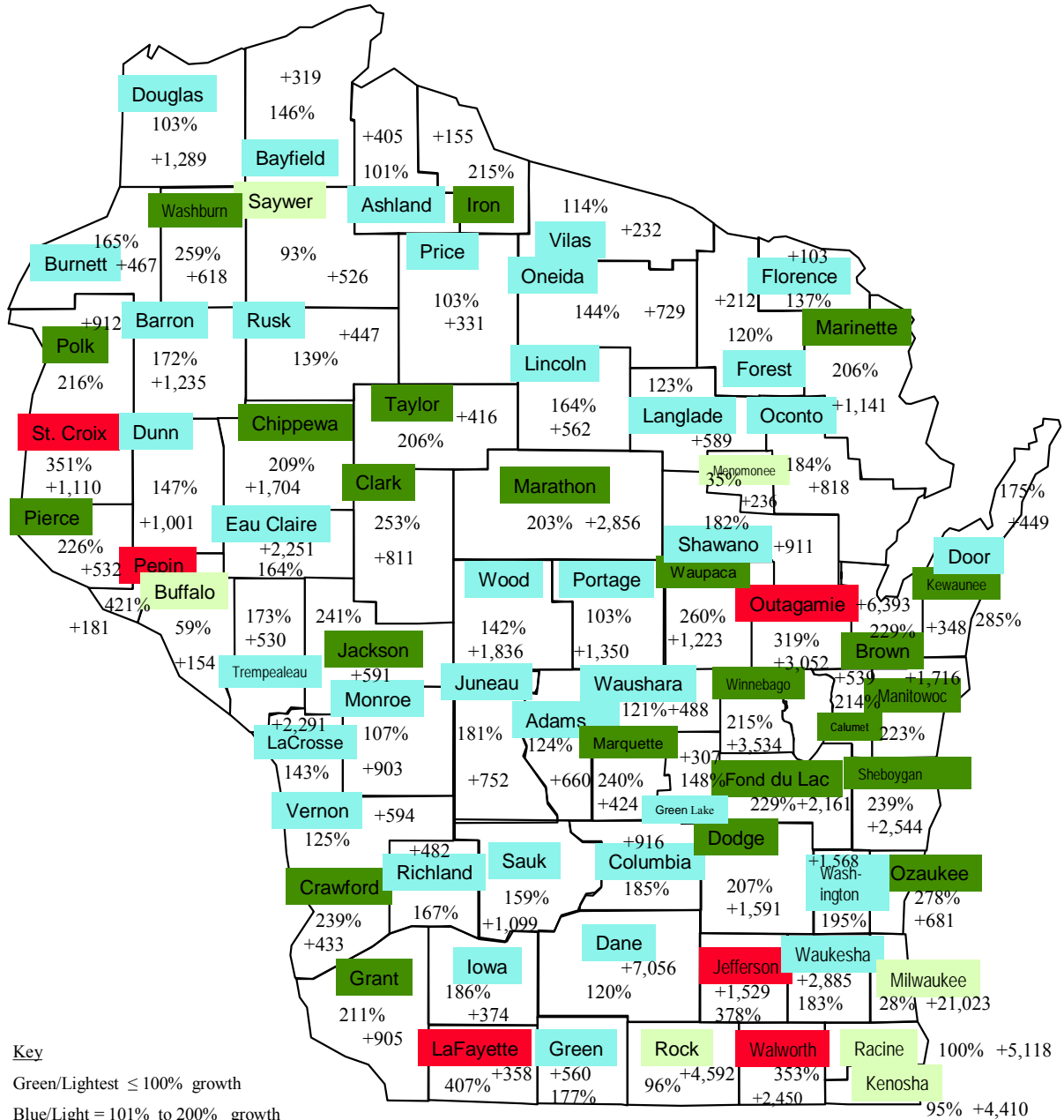
Relatively low percentage growth was observed in urban counties including Milwaukee, Racine, Kenosha and Rock. Milwaukee County (28 percent) and Menomonee County (35 percent) showed the lowest percent increase among the counties, suggesting higher initial penetration rates in these counties.

Counties were ranked in five classes from most rural to most urban. This analysis showed the following:

- Near-urban counties with 61 percent to 80 percent of their populations in urban areas had the highest average AFDC MA enrollment increase, 204 percent;
- Urban counties with 81 percent to 99 percent of their populations living in urban areas had the lowest average increase, 139 percent; while
- Less-urban counties with 21 percent to 60 percent of their populations in urban areas had an average 195 percent increase, while rural counties (below 21 percent urban) had an average 180 percent increase.

The data used in this analysis were not controlled for population growth, which could mitigate the findings in some counties.

Map 1: Counties by Number and Percent of Increase in AFDC
Medicaid Individuals January 2001 compared to January 2005

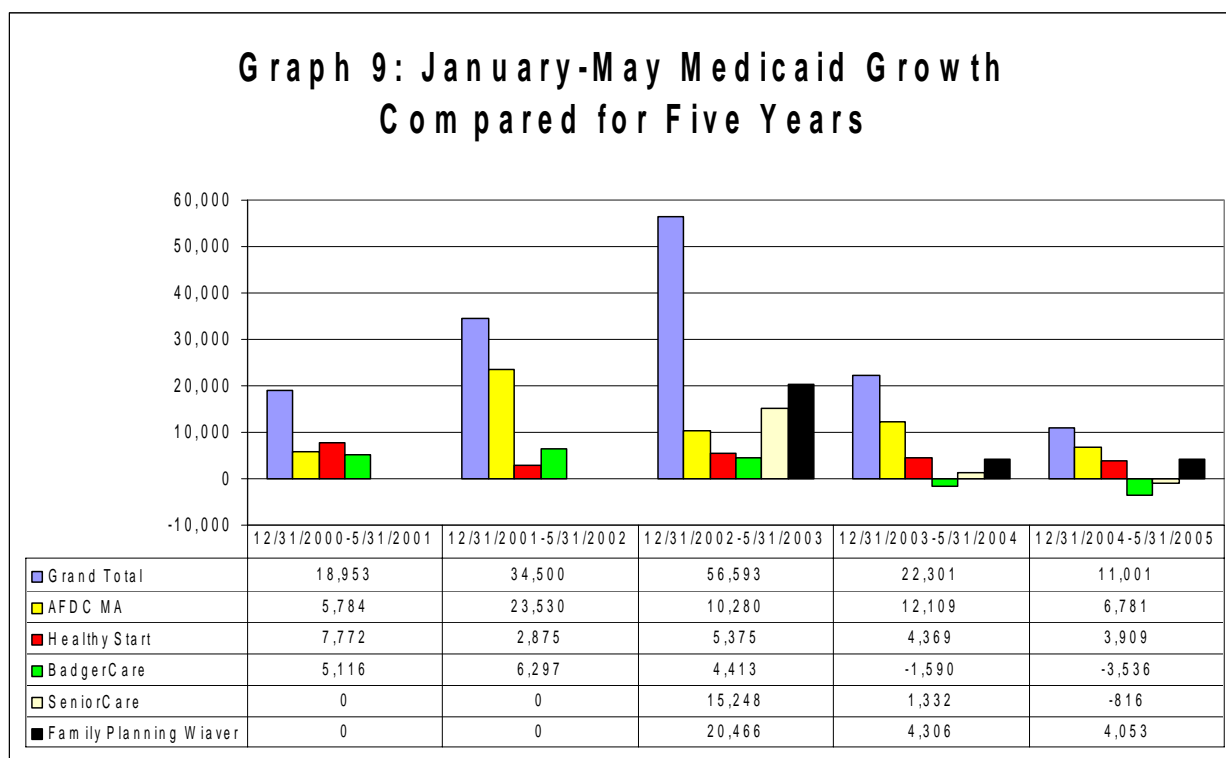


Future AFDC MA Enrollment Directions

Question #9: What are Medicaid enrollment trends in 2005?

Growth in Medicaid enrollment has slowed in the first quarter of 2005. April 2005 growth was high compared to the first three months of the year, but overall growth during May 2005 was the lowest this year and AFDC MA growth was the lowest since December 2003.

Graph 9 compares growth/loss during the first five months of 2005 with the same time period for the preceding four years. Overall growth through the first five months of 2005 has slowed compared to the same time period during the previous four years, and new AFDC MA enrollees are about 56 percent of last year's five-month total. Healthy Start growth remains steady at nearly the same pace as last year, as does growth in the Family Planning Waiver. SeniorCare and BadgerCare totals have declined.



Question #10: How does the current economic recovery, as measured by unemployment rate, compare with the unemployment rates associated with past declines in the AFDC MA caseload?

The rate of improvement in the economy since January 2004, as measured by unemployment rates, remains well below employment rates that have been associated with decreases in AFDC MA caseload in the mid-1990s.

Unemployment in Wisconsin averaged 5.0 percent in 2004, and 4.7 in 2005, through April. Similar unemployment rates occurred from January 1989 through May 1994, when AFDC MA enrollment averaged around 287,000 per month.

The drop in AFDC MA enrollment that began around June 1994 was *preceded* by 18 months of unemployment averaging 4.5 percent after falling below 5 percent for the first time in two years in December 1992. The actual decline that started in 1994 was *accompanied* by a sustained and steady drop in the unemployment rate. It averaged 4.2 percent during the last six months of 1994, and fell to 3.9 percent in November 1994, and remained below 4 percent for the next 74 months until February 2001. During this period, AFDC MA enrollment dropped 53 percent, from 278,419 in May 1994 to 130,539 in January 2001.

In February 2001, AFDC MA enrollment began its current increase. This month also marked the first month that unemployment climbed to 4 percent since October 1994. Unemployment rates in Wisconsin averaged 4.4 percent in 2001, 5.3 percent in 2002, 5.6 percent in 2003, 5.0 percent in 2004, and 4.7 percent through April 2005.

While the April 2005 unemployment rate is lower than previous years, the current drop in unemployment has been neither sustained (it was 5 percent as recently as May 2004) nor steady. It increased to a seasonally adjusted 4.9 percent in February 2005 after fluctuating between 4.6 percent and 4.7 percent during the last four months of 2004. As noted above, AFDC MA enrollment in the early 1990s did not fall until there was sustained unemployment averaging 4.2 percent in late 1994.

Question #11: How does the current economic recovery, as measured by manufacturing jobs, compare with the number of manufacturing jobs associated with past declines in the AFDC MA caseload?

The number of manufacturing jobs in Wisconsin today is far below the number in the past, and the slight increase seen from January 2004 remains well below the number associated with decreases in AFDC MA caseload in the mid-1990s. As noted, manufacturing jobs are more likely to offer health insurance than jobs in many other labor sectors, so gains and losses in manufacturing jobs can have a significant effect on AFDC MA caseload levels.

From January 1990 through May 1994, AFDC MA enrollment averaged 287,287 per month. During this period, the average number of manufacturing jobs in Wisconsin was 524,000. The decrease in AFDC MA was accompanied by an increase in manufacturing jobs, which peaked at 599,000 in March 2000, before beginning to decrease.

When AFDC MA began to increase in February 2001, there were still approximately 584,000 manufacturing jobs in Wisconsin. The number fell sharply by July 2001 to 558,100 and

continued to fall to a low of about 499,200 in January 2004. Manufacturing jobs have recovered very little in the last 16 months, reaching an estimated 503,800 in April 2005.

As with unemployment rate, we are not in a position to confidently assess the level of manufacturing employment the state needs before AFDC MA enrollment significantly declines. However, the data presented above shows that manufacturing employment is a strong predictor of AFDC MA enrollment levels. It remains to be seen if the current level of manufacturing employment (about 504,000 jobs) will allow a decline in AFDC MA enrollment or if additional job growth in this sector is a pre-requisite. The historic data show that the number of manufacturing jobs currently remains about 20,000 below the 1994 level, when the AFDC MA caseload last began to fall.

It is also worth noting that manufacturing jobs represented 20.2 percent of Wisconsin's labor force in January 1990, 19.8 percent in January 1995, 19.9 percent in January 2000, but fell to 16.3 percent in January 2005. Extrapolation from data in the May 31, 2005 DOR quarterly report Wisconsin Economic Outlook suggests it could decline to 15.9 percent by January 2010, if the projections hold. It is possible that the current increase in caseload represents a return to historical levels that will be mitigated by future economic development. However, it is also possible that the decline in jobs offering affordable insurance to low income persons represents a long-term structural change in the job market that will result in a higher number of low-income persons eligible for MA and BadgerCare in the future.

Appendix I

How does Medicaid caseload growth in Wisconsin compare with the nation as a whole, and with neighboring states?

After excluding partial benefits programs (SeniorCare, the Family Planning Waiver, and Medicaid-Medicare eligibles in Wisconsin), Wisconsin's Medicaid percentage increase remains higher than neighboring states and the nation as a whole. A 2004 Kaiser report showed that total Medicaid enrollment in the United States has increased since June 1997.⁸ The rate of growth quickened around June 2000, then slowed around December 2002.

While initial national caseload growth was probably due to State Children's Health Insurance Program (SCHIP) initiatives (just as BadgerCare spurred Wisconsin's growth), the Kaiser authors believe that the slowdown in state fiscal year 2003 was not due to an improving economy but to actions taken by many states to limit enrollment. Twenty-five states reported such actions, including reducing or cutting eligibility, imposing new or increased fees or premiums, reversing previous simplifications in the application or renewal process, capping enrollment in waiver programs, adopting more stringent requirements for admission to nursing homes or waiver programs, and/or reducing the time allowed for continuous eligibility or transitional Medicaid,

The Kaiser report data in Table 1 below covers the calendar period from June 1997 through June 2003, and includes only full coverage enrollees. Pharmacy Benefit enrollees (Wisconsin SeniorCare) and Family Planning Waiver enrollees are not included. Medicaid-Medicare dual eligibles were excluded when possible from the data, but this was not possible for all states, and account for less than one-fifth of one percent of enrollees in the table. They are excluded from the Wisconsin data.

Wisconsin's Medicaid percentage increase of full coverage enrollees is higher than the nation and neighboring states. Adding adults to BadgerCare was one factor that increased Wisconsin's growth relative to the nation. (As of June 2003, only seven states, including Wisconsin, were using SCHIP funds to cover adults.) When the adults enrolled in Wisconsin's BadgerCare are subtracted from the analysis, Wisconsin would still have had higher growth than neighboring states, but its total would have resulted in growth in line with the national average over these six years, all other factors remaining equal.

⁸ Medicaid Enrollment in 50 States Prepared by Eileen R. Ellis, Vernon K Smith, Ph.D, and David M. Rousseau, Kaiser Commission on Medicaid and the Uninsured; issued October 2004. Data based on point in time (June) counts.

Medicaid Percentage Growth SFY 1998-SFY 2003; Wisconsin Compared to USA and Neighboring States

	USA	Wisconsin	Minnesota	Iowa	Illinois	Michigan	Adjusted WI *
SFY 1998	-2.4%	-6.0%	-5.9%	-3.7%	-4.7%	-0.8%	-6.0%
SFY 1999	2.0%	-0.5%	4.9%	-2.8%	0.2%	-3.0%	-0.5%
SFY 2000	3.7%	21.2%	1.9%	1.5%	6.5%	-0.8%	9.3%
SFY 2001	8.3%	7.4%	7.5%	10.7%	4.8%	6.9%	5.8%
SFY 2002	9.8%	13.7%	2.2%	8.6%	1.4%	8.0%	13.5%
SFY 2003	5.9%	7.9%	8.4%	7.6%	8.5%	6.6%	7.5%
Total	30.1%	49.3%	19.7%	23.0%	17.3%	17.4%	29.6%

* Enrollment trends after subtracting out adults being served in BadgerCare.

Appendix II

Table 1: Rural-Urban Counties

Rural				Urban
0-20% urban	21-40% urban	41-60% urban	61-80% urban	81-100% urban
Adams	Barron	Ashland	Douglas	Brown
Bayfield	Columbia	Calumet	Eau Claire	Dane
Buffalo	Crawford	Chippewa	Fond du Lac	Kenosha
Burnett	Door	Dodge	Manitowoc	La Crosse
Clark	Grant	Dunn	Outagamie	Milwaukee
Florence	Green Lake	Green	Ozaukee	Racine
Forest	Iron	Jefferson	Portage	Waukesha
Iowa	Jackson	Langlade	Rock	Winnebago
Juneau	Marinette	Lincoln	Sheboygan	
Kewaunee	Oneida	Marathon	Walworth	
La Fayette	Pierce	Monroe	Washington	
Marquette	Richland	St. Croix	Wood	
Menominee	Rusk	Sauk		
Oconto	Shawano			
Pepin	Taylor			
Polk	Waupaca			
Price				
Sawyer				
Trempealeau				
Vernon				
Vilas				
Washburn				
Waushara				